TN Department of Children's Services

June 1, 2021

Katherine Stickel, Director
Division of State Audit
Cordell Hull Building
425 Fifth Avenue North
Nashville, TN 37243

Dear Ms. Stickel,

Please find attached the Report of Action on 2020 Performance Audit Recommendations prepared by the Department of Children's Services to address the findings and the observations identified in the department's 2020 Performance Audit Report.

Should you have any questions or need any additional information or documentation, please contact me or Jennifer Donnals, chief of staff, at 615-253-7716 or via email at jennifer.donnals@tn.gov.

Sincerely,

Jennifer Nichols
Commissioner

Department of Children's Services

Department of Children's Services
Report of Action on 2020 Performance Audit Recommendations
June 1, 2021

FINDING 1

The Office of Juvenile Justice staff did not consistently document their supervisory review of family service workers' probation and aftercare supervision; did not perform the required number of contacts for probation and aftercare; and did not document actions taken for electronic monitoring alert notifications

RECOMMENDATION

The Commissioner, the Deputy Commissioner of Juvenile Justice, and the Executive Director of the Office of Juvenile Justice should require team leaders to consistently document their review of probation and aftercare cases to ensure family service workers perform the required level of supervision. Management should continue working to improve internal controls over management's supervisory review of staff who have responsibility to ensure children on probation and aftercare supervision meet those requirements. Management should ensure staff are aware of and follow department policy and should require staff to use available reports as part of the supervisory review process.

In addition, management should continue to develop and instate the new electronic monitoring division to review electronic monitoring cases and ensure the division's staff document actions taken to resolve the alert notifications.

Management should perform an adequate risk assessment to identify all risks associated with probation and aftercare supervision. Management should implement effective controls to address the risks noted in this finding and in management's risk assessment as necessary; assign staff to be responsible for ongoing monitoring of the risks and mitigating controls; and take action if deficiencies occur.

ACTION OWNER

Darren Goods, Deputy Commissioner, Office of Juvenile Justice
Misty Neely, Executive Director, Office of Juvenile Justice

CORRECTIVE ACTION COMPLETED

Face-to-face visits

- Created and now using a new report to track face-to-face contacts within the first 30 days of supervision. **Report developed in December 2020; training occurred on**

January 11, 2021.

- Developed a new protocol for supervisors that establishes the specific reports they must use monthly to track case manager contacts; includes submitting a standard monthly report that tracks contact with youth. This process was written into the supervisors' 2021 job performance plans. **Protocol completed December 7, 2020; staff started following protocol January 2021.**

- Simplified DCS Policy 13.11, "Trial Home Visits and Aftercare Requirements for Delinquent Youth" and Policy 13.12, "Probation Requirements for Delinquent Youth," along with the Manual For Juvenile Justice Intensive Probation and Aftercare to reduce the number of steps to adequately measure face-to-face visits and set clear expectations for front line case managers. Also created a manual for case manager reference. **Updated policies signed and effective December 21, 2020; juvenile justice staff statewide trained in January 2021.**

- Developed internal controls, including a protocol for face-to-face fidelity reviews using a specialized tracking report to ensure face-to-face visits are complete as required and documentation occurs. The fidelity review spreadsheet is uploaded on a shared drive monthly. **Protocol developed and in use January 2021.**

- Started tracking documented face-to-face visits in October 2020 to measure compliance:

    - Probation – Three face-to-face visits within first 30 days (statewide average)
        - October 2016 – July 2020 56% (2020 Performance Audit period)
        - October – December 2020 78.9%
        - January – March 2021 91.5%

    - Probation – Required monthly face-to-face visits per supervision level
        - October 2016 – July 2020 71% (2020 Performance Audit period)
        - October – December 2020 91.7%
        - January – March 2021 96.1%
        - April 2021 98.3%

    - Aftercare – Three face-to-face visits within first 30 days
        - October 2016 – July 2020 77% (2020 Performance Audit period)
        - October – December 2020 88.0%
        - January – March 2021 96.5%

- Aftercare – Required monthly face-to-face visits per supervision level
  - October 2016 – July 2020 68% (2020 Performance Audit period)
  - October – December 2020 89.8%
  - January – March 2021 93.8%
  - April 2021 96.2%

Electronic monitoring

- Created an Electronic Monitoring Unit (EMU) that consists of one supervisor and eight staff who provide support to case management staff 24 hours a day, seven days a week. Conducted an extensive two-week training for EMU staff with the system provider and established protocols for case managers and EMU staff to ensure all actions taken are documented. **First day of EMU operation October 11, 2020.**

- Developed internal controls, including a protocol for EMU fidelity review using a specialized tracking report to ensure the protocols are followed and required documentation occurs. **Internal controls developed and review process and tracking report finalized December 7, 2020.**

- Now require monthly reviews of alerts worked and documentation to be completed by the 10th day of each following month. **Action started January 2021.**

- Electronic monitoring device alerts/notifications received since November 2020:

  - November 2020: **3,353**
  - December 2020: **4,757**
  - January 2021: **4,740**
  - February 2021: **6,645**
  - March 2021: **8,722**
  - April 2021**:** **8,101**

FINDING 2

The department staff did not maintain accurate and complete lists of volunteers and did not perform and maintain background checks on employees and volunteers in accordance with state statute and departmental policy.

RECOMMENDATION

The Executive Director of Human Resources should ensure that regional Human Resources staff and volunteer coordinators keep accurate, complete volunteer records as a basis for initiating the background check process. The Office of Human Resources

should conduct a comprehensive review to ensure that all existing departmental employees and volunteers have completed background check results on file. The Commissioner and the Executive Director of Human Resources should ensure that all the required background checks are completed as required in a reasonable timeframe. The Executive Director of Human Resources should also implement sufficient controls to ensure that staff accurately and completely document their review on the internal checklist.

Additionally, management should perform an adequate risk assessment to identify all risks associated with completing background checks for employees and volunteers. Management should implement effective controls to address the risks noted in this finding and based on their own risk assessment; assign staff to be responsible for ongoing monitoring of the risks and mitigating controls; and take action if deficiencies occur.

ACTION OWNERS
Martha Shirk, Executive Director of Human Resources and Internal Affairs
Michelle Reiter, Program Director, Office of Child Programs

CORRECTIVE ACTION COMPLETED

Employee background checks

- Human Resources staff have reviewed ***all*** 3,452 current personnel files and discovered some deficiencies in background checks. **File review completed May 28, 2021; all deficiencies to be corrected by June 15, 2021.**

- All existing HR staff and new HR staff hired after December 8 have been re-trained or trained on Policy 4.1, "Employee Background Checks." **All existing employees trained by January 31, 2021.**

- Created an internal control by establishing a new procedure to require Central Office HR manager or designee to review pre-employment documentation before approving new hires to be entered into Edison through ePAF. (Pre-employment checks include all background checks, references, and proof of education.) If background checks are not completed, files are returned to field HR staff and candidate will not be entered into Edison through ePAF. **Internal control created and procedure implemented December 2020.**

- Created an internal control by requiring Regional HR Directors to conduct an additional file audit of new employees each quarter using an audit checklist. The

Regional HR Directors meet with staff responsible for the background checks to cover any deficiencies; each quarter Regional HR Directors are to report problems or issues to department Director of Human Resources and Internal Affairs. This procedure has been written into the Regional HR staffs' 2021 job performance plans. **Quarterly review process started January 2021.**

Volunteer background checks

- Central Office Child Programs staff reviewed ***all*** 276 current and 62 new volunteer files, including all required documentation, dated background checks and dated applications, to ensure DCS Policy 4.1, "Employee Background Checks" requirements have been met. Any missing documentation has been corrected. **Files reviewed and documentation corrected as of April 30, 2021.**

- All regional volunteer coordinators re-trained on **December 7, 2020; newly hired volunteers coordinators will be trained as hired.**

- Created an internal control by establishing new protocol requiring regional volunteer coordinators to submit volunteer files to Central Office Child Program staff for review of all required documentation, including dated background checks and dated applications, to ensure Policy 4.1 requirements have been met; once review is completed and the file contains the proper documentation, regional volunteer coordinators will submit volunteer certification letter to Central Office HR. **Internal control created and new process started December 7, 2020.**

- All volunteer files are now maintained in a centralized folder on the department's shared drive. These files are now managed and will be reviewed annually by Central Office Child Program staff. **New process started December 7, 2020.**

FINDING 3

Management improved their response to allegations of child abuse; however, management and staff still have documentation weaknesses and delays in moving through key points of the investigative process

RECOMMENDATION

Management should ensure that all investigations are consistently and thoroughly conducted, documented, reviewed, and closed, and that staff meet key investigative time benchmarks. As a part of this effort, the department should continue to perform investigation quality reviews.

Management should perform an adequate risk assessment to identify all risks associated with fraud, waste, abuse, noncompliance, error of the department's operations, and ability to meet its mission. Management should then implement effective controls to address the risks noted in this finding and based on an adequate risk assessment. As necessary, management should assign staff to be responsible for ongoing monitoring of the risks and mitigating controls, and take action if deficiencies occur.

ACTION OWNER
Carla Aaron, Deputy Commissioner, Office of Child Safety

CORRECTIVE ACTION COMPLETED

- The Office of Child Safety focused efforts to correct findings through policy revisions, targeted training efforts, and regular data monitoring.
- Reviewing the data around the performance audit findings continues to be a standing agenda item in monthly meetings with the OCS Directors and Team Coordinators, and was discussed during the OCS All WebEx meeting in April 2021. This meeting included frontline case managers, supervisors, and directors statewide and included over 200 participants.
- The data dashboard for the performance audit measurements is provided weekly to the CPS Directors and shared with regional teams as a management tool. (See attached).

Family Advocacy and Support Tool Safety Assessments (FAST)

- Developed a performance measure for completion of FAST safety assessments that was added to the 2021 individual job performance plans for CPS investigators in **January 2021.**

  Performance measurements – FAST assessments submitted within five business days
  - Q3 2020: 68%
  - Q4 2020: 65%
  - Q1 2021: 71%
  - April 2021: 78% (the remaining days in May will impact this percentage)

Timely Classifications

- Develop and implement a specialized training on timely classifications with a focus on documentation and global assessments. **Training developed in Q4 2019 has been delivered in accordance with the CPS Reorganization roll out schedule. CPS staff in all regions will have completed this training as the statewide CPS Reorganization completes in June 2021; the training has been**

incorporated into training for new hires.

- Requiring timely classification included in the 2021 job performance plans for CPS investigators. **Action completed: January 2021.**

  Performance measurements – Cases timely classified (includes severe and non-severe abuse cases)
  - Q3 2020: 70%
  - Q4 2020: 67%
  - Q1 2021: 75%
  - Mar 2021: 77% Non-severe abuse cases (within 30 days)
    78% overall severe/non-severe abuse classification as of May 21 (this percentage will adjust due to severe abuse allegations having 60 days for classification)

Case Closure, Transfer, and Extension

- Updated the DCS Policy 4.4 "Performance and Case Supervision Practice Guidelines and Criteria" to require lead investigators to document in TFACTS an explanation for the delay and a plan for completing the case for all investigations open beyond 60 days. **Policy updated and signed October 6, 2020.**

- Created and conducted enhanced training for supervisors to ensure case extensions are documented within TFACTS; training recorded and uploaded into Edison for future utilization. **Training conducted October 23 – December 9, 2020.**

- Created a special report that tracks compliance to be used by supervisors to monitor investigator compliance. **Report completed and in use November 2020.**

Child Protective Investigative Teams and Severe Abuse Cases

- Update Work Aid 3 in Policy 14.7 "Child Protective Services Investigation Track" to specify which documents are to be uploaded. Previously, the policy did not outline this. **Work aid updated July 2020.**

  Quality service reviews conducted on a sample of 33 cases in Q1 2021:
  - Out of 33 cases randomly samples, 17 investigations not applicable (CPIT form not required)
  - Out of the 16 applicable cases, CPIT forms for 13 investigations (81.25%) were uploaded into TFACTS

- Out of the 16 applicable cases, CPIT forms for 3 investigations (18.75%) were not uploaded (as of May 20, 2021, all 3 forms have been uploaded into TFACTS)

Administrative Reviews

- Updated DCS Policy 4.4 to mandate that all supervisors enter administrative reviews into TFACTS and eliminate the options for multiple points of data entry. **Policy updated and signed October 6, 2020.**

- Created an Administrative Review Report to measure compliance and updated the tool supervisors use to review cases, to include the required timeframes outlined in Policy 4.4 and clarifies expectations. **Report created and in use October 2020.**

  Performance measurements – Administrative reviews held for cases not closed, transferred, or extended within 60 days
  - Q3 2020: 69%
  - Q4 2020 73%
  - Q1 2021 80%
  - April 2021 83% (the remaining days of May will impact this percentage)

FINDING 4

Management did not have a sufficient monitoring process to document and analyze that provider agencies had performed all required background checks for provider employees before they were hired.

Recommendation

The Commissioner, the Assistant Commissioner of the Office of Continuous Quality Improvement, and the Director of Provider Monitoring and Evaluation should ensure that monitors

1. carefully document on the personnel tool all critical aspects of their reviews for provider background and safety checks, and
2. identify background checks that were not completed before the provider employee started work.

Management should perform an adequate risk assessment to identify risks associated with fraud, waste, abuse, noncompliance, error of the department's operations, and mission. Management should then implement effective controls, based on an adequate risk assessment, to address the risks noted in this finding. As necessary, management should assign staff to be responsible for ongoing monitoring of the risks and mitigating

controls, and take action if deficiencies occur.

ACTION OWNERS
Jennifer Williams, Assistant Commissioner, Office of Continuous Quality Improvement
Brenda Myers, Director, Provider Monitoring and Evaluation (PME)

CORRECTIVE ACTION COMPLETED

- Modified the monitors' personnel review tool to include a data field under each question where the completion date of each pre-hire check is recorded and the review is entered into REDCap, the electronic database created for DCS by Vanderbilt University Center for Excellence. **All PME monitors are have been using the modified tool during provider annual reviews and have been required to enter information into REDCap since October 21, 2020.**

- **In January 2021, an additional comment section was added to the tool** providing clear and consistent fields where PME monitors can record discrepancies and/or deficiencies during reviews.

- Revised protocol regarding third party background checks; PME monitors now document the date the agency received the completed third party check and mark it compliant if it occurred prior to hire. **PME monitors trained on new protocol in January 2021; specific instructions for this protocol were added into REDCap and on the pre-hire review tools in February 2021.**

- Worked with Vanderbilt to build an enhancement within RedCap to automatically verify compliance for dates entered for each check against the employee's hire date as an additional level of oversight. **Enhancement completed in February 2021; test reports reveal the enhancement is performing as designed to indicate date fields that have not been recorded in REDCap.**

FINDING 5
Licensing Division staff did not maintain documentation to support the conclusion that juvenile detention centers met staffing ratios.

RECOMMENDATION
The Commissioner and the Licensing Division Director should ensure staff maintain documentation to support their conclusions that juvenile detention centers complied with the required staffing ratios specified in the department's rule.

ACTION OWNERS
Jennifer Williams, Assistant Commissioner, Office of Continuous Quality Improvement
Mark Anderson, Director, Licensing

CORRECTIVE ACTION COMPLETED

- Developed a standard tool now used by all licensing staff to document records reviewed to determine staffing ratio compliance at licensed juvenile detention centers and all residential facilities licensed by DCS. The standard tool ensures consistent documentation of the pertinent information reviewed and further ensures a consistent sample size. **Tool developed and put into use by licensing staff September 1, 2020.**

- Now require all licensing staff to maintain completed licensing review tool in the appropriate juvenile detention center or residential agency licensing file to ensure consistent documentation of all ratio reviews and sampling. Procedure implemented **September 1, 2020.**

- Created an internal control by requiring annual licensing evaluation summaries to include documentation reflecting that the standard minimum sampling has been met for the annual licensing period. Any findings in this area are noted in the licensing evaluation summary. Under new protocol, no annual evaluation summaries are approved without documentation that this minimum sampling threshold has been met. Compliance is reviewed by the licensing director and entered into a tracking sheet as licensing summaries are approved. **Internal control created and new protocol implemented by staff on January 1, 2021.**

- Created an internal control by conducting a quarterly quality assurance review of randomly sampled agency files to ensure proper documentation is kept, including date ratio checks are completed during facility reviews. **Internal control and quality assurance review created in January 2021.**

FINDING 6
The department's PREA compliance managers did not complete the Wilder Youth Development Center's PREA staffing pattern assessment

RECOMMENDATION
Wilder's PREA Compliance Manager and the department's statewide PREA Coordinator should ensure that Wilder's PREA staffing pattern assessment is completed each year.

ACTION OWNER
Darren Goods, Deputy Commissioner, Office of Juvenile Justice
Misty Neely, Executive Director, Office of Juvenile Justice

CORRECTIVE ACTION COMPLETED

- Revised DCS Policy 18.8, "Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault, or Rape Incidents and Prison Rape Elimination Act," to specify the employee responsible for ensuring timely completion of the Staffing Plan Assessment annually. **Policy revised October 28, 2020.**

- Updated the protocol for the Statewide PREA Coordinator (a supplement to Policy 18.8) to create an internal control requiring the Statewide PREA Coordinator to obtain a copy of the signed Staffing Plan Assessment. **Protocol updated and internal control created September 2020**

- **The PREA staffing pattern assessment for this calendar year was completed February 23, 2021.**

- PREA staffing pattern assessment will be completed annually by March 31; **this requirement will be written into the Statewide PREA Coordinator's 2022 job performance plan.**

FINDING 7
The Office of Continuous Quality Improvement staff did not have evidence that they followed up on provider employees or conducted in-depth reviews on provider employees or department employees who were investigated for violating department standards, contract provisions, or state regulations

RECOMMENDATION
The Commissioner and the Assistant Commissioner of the Office of Continuous Quality Improvement should ensure that staff maintain documentation of the dates and the corrective actions providers took to address the department's concerns. Additionally, the Commissioner and the Assistant Commissioner should ensure the Office of Continuous Quality Improvement to create a protocol that requires the Provider Quality Team Division to conduct in-depth reviews or follow up on Wilder employees who have been named as an alleged perpetrator in multiple investigations. The Provider Quality Team Division should document all in-depth reviews or monitoring and maintain that documentation.

Management should perform an adequate risk assessment to identify risks associated with fraud, waste, abuse, noncompliance, error of the department's operations, and mission. Management should then implement effective controls, based on an adequate risk assessment, to address the risks noted in this finding. As necessary, management should assign staff to be responsible for ongoing monitoring of the risks and mitigating controls, and take action if deficiencies occur.

ACTION OWNER

Jennifer Williams, Assistant Commissioner, Office of Continuous Quality Improvement
Crystal Parker, Executive Director, Office of Continuous Quality Improvement

CORRECTIVE ACTION COMPLETED

- Reinforced with PQT staff the importance of maintaining evidence that Provider Quality Team staff did follow up on provider employees and continue to store documentation, including meeting minutes where actions taken were discussed; continue to store on office shared drive unannounced and announced site visit reports, spreadsheets that track Special Investigation Unit (SIU) investigations on facilities and individual employees (including actions taken), PQT/SIU history review reports, and provider performance improvement plans. **Action completed October 22, 2020.**

- Revised PQT protocol to include conducting in-depth reviews of both provider employees and departmental employees who were investigated for violating department standards or state regulations at the state youth development center (Wilder). **Protocol revised October 22, 2020.**

- Improved provider monitoring by obtaining contract provider/youth development center(s) employee retraining documentation and termination/resignation information on alleged perpetrators identified in SIU investigations during incidents in which a PQT member expresses concerns. (All documentation is saved on the shared drive.) **Action step implemented and PQT staff trained in October 2020.**

- Improved data tracking and trending by utilizing a specialized program manager from the DCS Performance & Quality Improvement Data Quality team to create quarterly and annual reports of provider trends, including frequency and types of Special Investigation Unit (SIU) investigations, provider related concerns, and incident reports. **Additional tracking logs were added to ensure actions steps are completed timely. Action step implemented in October 2020.**

FINDING 8

Management did not ensure staff maintained and protected the department's public records as required by statute

RECOMMENDATION

The Commissioner should ensure that all the department's public records have RDAs approved by the Public Records Commission and that staff follow all established public records requirements. Additionally, management and staff must adhere to the department's litigation hold and follow the necessary requirements of the Records Management Division before destroying any public records.

ACTION OWNERS

Mohamed El-Kaissey, Assistant Commissioner, Budget and Finance
Chuck Brown, Records Custodian
Martha Shirk, Executive Director, Human Resources and Internal Affairs

CORRECTIVE ACTION COMPLETED

- Filed new or updated records disposition authorizations to properly follow all established public records requirements. At the request of the department, **the State of Tennessee Public Records Commission approved the following DCS records disposition authorizations on September 21, 2020**:
    - RDA 2983 addresses the destruction of closed licensure files and was modified to extend the retention of these closed files from three to five years;
    - RDA 11385, a new RDA that addresses the destruction of closed provider monitoring files and sets the retention of these closed files at five years.

- **The commission also approved on September 21, 2020,** additional RDAs and retired another, at the request of DCS:
    - RDA 10223 was modified to mandate permanent retention of closed DCS education records, provisions that were previously part of RDA 2881 which has been retired;
    - RDA 2899 was modified to establish five years retention of DCS safety program files;
    - RDA 11387 is a new RDA and mandates five years of retention of Continuous Quality Improvement meeting minutes records; and
    - RDA 2881 was retired as the records now fall under RDA 10223 (see above).

- The department's Human Resources office implemented a new procedure to scan separated employees' files and save electronic copies to the shared HR drive

before sending the files to Department of Human Resources. **Procedure implemented December 2020.**

FINDING 9

Department management and Strategic Technology Solutions management did not provide adequate internal controls in one area, increasing the risk of unauthorized access to sensitive data

RECOMMENDATION

Department and STS management should correct these conditions by promptly developing and consistently implementing internal controls in these areas. Management should implement effective controls to ensure compliance with applicable requirements; assign staff to be responsible for ongoing monitoring of the risks and mitigating controls; and take action if deficiencies occur.

ACTION OWNER

Wayne Glaus, Chief Information Officer
Martha Shirk, Executive Director, Human Resources and Internal Affairs

CORRECTIVE ACTION COMPLETED

- Department management has taken the following steps to address the finding:
  - Edison now requires a security form for termination be submitted prior to the ePAF being approved at the Agency and DOHR level. **This was completed in Fall 2020 as an enterprise-wide update to Edison.**

  - Created an internal control by implementing a procedure that mandates regional HR staff attach a copy of the termination request submitted to STS to the termination ePAF, so that Central Office HR staff can confirm**. Internal control and** p**rocedure implemented December 2020.**

- Working with STS, in accordance with the Enterprise Information Security Policy, Section 5.2.6, (listed below) the department has taken the following steps:
  - Performed a risk assessment on risks associated with information systems access. **Completed March 31, 2021.**

  - Implemented effective controls to address identified risks. **Completed March 2021.**

  - Developed automation to help ensure that termination tasks are carried

out within the specified policy guidelines. **Completed May 31, 2021.**

- Developed and maintain logs that support the process and record SLA adherence. **Completed May 31, 2021.**

FINDING 10

Although department management took steps to improve TFACTS' performance and network issues, the TFACTS financial functions are still not fully implemented after 10 years

RECOMMENDATION

Department management should continue their efforts to complete TFACTS' financial enhancement project in order to meet the expected go-live date, and we will review the new financial module during the next performance audit.

ACTION OWNER

Wayne Glaus, Chief Information Officer

CORRECTIVE ACTION COMPLETED

- **Commissioner created a steering committee in January 2020** composed of technical developers, program directors, fiscal users, and STS and DCS management to meet weekly and spearhead the completion of the fiscal enhancement to TFACTS. Starting in April 2021, the steering committee has met at least twice weekly as the team, both STS and DCS fiscal and programs, has worked tirelessly to build, test and remediate issues to ensure a quality product. TFACTS has remained fully operational for both program and fiscal staff during this time.

- **As of June 1, 2020, STS continues to work** on remediating issues and re-engineering functions that have been identified as needing to be changed after initial development.

- Staff and provider training curriculum were developed and delivered by DCS training division **in March and April 2021.**

- Communications plan was developed **in May 2021** and is ready for implementation prior to fiscal enhancement go live.

OBSERVATION 1

Department management should amend the department's rule related to placements of more than six children in a foster home

RECOMMENDATION

The Commissioner and the Office of Child Programs should quickly work to finalize and file the amended rule for foster homes placements involving more than six children. In the meantime, management should ensure staff follow all policy requirements when making exceptions to the department's existing rule. Ultimately, when the amended rule is approved, management should adhere to the rule as approved and any applicable policy to ensure the department acts in the best interest of the children and their families.

ACTION OWNERS

Doug Dimond, General Counsel
Sandra Wilson, Deputy Commissioner, Office of Child Programs

CORRECTIVE ACTION COMPLETED

- Filed with the Secretary of State's Office an emergency rule to amend the previous rule that did not allow the department to make exceptions to placing more than six children in a home. **Action completed November 2, 2020.**

- Permanent rulemaking hearing held on March 29, 2021. The rule was transmitted to the Attorney General's Office on April 20, 2021, for review and signature. It was signed and returned on May 26, 2021 and has been refiled with the Secretary of State's Office.

- Revised current DCS Policy 16.46 to further clarify case managers' responsibilities for properly completing and documenting the placement exception request forms. **Policy revised and signed on August 21, 2020.**

- Appropriate staff re-trained on Policy 16.46 and the accompanying protocol in **September 2020**.

- The Office of Child Programs will create an internal control by developing a uniform tracking log to be added to a departmental system drive until the

TFACTS enhancement project is completed. The enhanced system will automatically capture cases needing a placement exception request (PER) and generate a notice to the field staff.

OBSERVATION 2

Management should improve their process to monitor case managers' caseload counts

MATTER FOR LEGISLATIVE CONSIDERATION

Section 37-5-132, *Tennessee Code Annotated*,requires the department to maintain staffing levels within a region to ensure a maximum average caseload of 20 cases. State statute, however, does not identify what *time period* (monthly, quarterly, annual) the department should use to determine this average.

When management elects to use a longer time period for the average, such as an annual average, management risks case managers carrying a higher number of actual cases for an extended period of time while still meeting the maximum average caseload of 20 cases. The General Assembly may wish to consider amending statutory language to define the *time period* for the average caseload calculation (monthly, quarterly, annual).

ACTION OWNERS

Drew Wright, Executive Director of Legislation and Policy
Doug Dimond, General Counsel

CORRECTIVE ACTION COMPLETED

- The department is committed to addressing this issue through legislation and has taken several steps over the past six months to prepare for that process:
    - The DCS legislative team has been in conversation with Chairman Ragan throughout the 2021 legislative session. Chairman Ragan has been very helpful in articulating the value of being able to incorporate real-time analytics of the department's data and apply it to the department's daily operations. This will improve outcomes for the children and families DCS serves, increase operational efficiencies, and better support DCS caseworkers. The Governor's legislative team is committed to working with the Department to address this observation legislatively in the coming year
    - The department is currently modifying the process for analyzing caseload counts and has already started two "point-in-time" counts per

month. The data team is working actively to develop a more robust way to pull this data and learn more about trends, outliers, etc.

- Department leadership continues to meet monthly to review the caseload data.

- The Department is actively preparing to go live with full implementation of the Family First Prevention Services Act (FFPSA) in July 2021 and will complete the roll out the Child Protective Services (CPS) redesign across the state by the end of June 2021. Addressing caseload legislation in 2022 will allow the department to align any changes with these programmatic implementations. Additionally, the department can use data the impact of the Juvenile Justice Reform Act, Drug Teams, and Safe Baby Courts when addressing this legislation

- A market salary adjustment for caseworkers was requested and approved by the General Assembly for the FY2022 budget; this is an initial step to help address turnover and is expected to have a positive impact on caseloads.

OBSERVATION 3

Licensing Division management had not developed formal policies and procedures for supervisory reviews and documentation requirements

RECOMMENDATION.

We offer that management should formally document all key processes to ensure business operations can continue through unexpected events, changes, or personnel turnover.

ACTION OWNERS

Jennifer Williams, Assistant Commissioner, Office of Continuous Quality Improvement
Mark Anderson, Director, Licensing

CORRECTIVE ACTION COMPLETED

- Updated licensing approval log to reflect the date each report was reviewed, approved, and signed by the director of licensing. Created an internal control by now requiring director to ensure that both the consultant and director signs the reports before they are finally distributed electronically to the agency, the agency's board, and department stakeholders and are archived by

the licensing consultant on the departmental server. **Action completed September 2020.**

- Converted all licensure record keeping as of January 1, 2021, from paper to an almost exclusively electronic format. **All applicable records converted by June 1, 2021**; previous paper records kept in accordance with the appropriate records disposition authorization. **The Licensing Director will conduct a review of consultants' files from June 11 through 25, 2021, to ensure they are current and complete.**

- Created an internal control by conducting a quarterly quality assurance review of randomly sampled agency files to ensure proper documentation is kept, including licensing director signature on final summaries of licensing approval. **Internal control and quality assurance review created in January 2021.**

OBSERVATION 4

The department's contract requirements for hardware-secure residential child caring agencies contradict the department's rule governing staffing levels.

RECOMMENDATION

With conflicting staffing level guidance, the department increases the risk that hardware-secure RCCAs will not meet required staff levels to properly supervise children at the facilities. The Commissioner and management should promptly determine the appropriate staffing ratio requirements for hardware-secure RCCAs and should take appropriate steps to align all guidance for the facilities.

ACTION OWNERS

Helen Rodgers, Assistant General Counsel
Mark Anderson, Director, Licensing

CORRECTIVE ACTION COMPLETED

- Amended the department's Contract Provider Manual to ensure that the ratio requirements in the Department's rule and policy are consistent. **Action completed October 27, 2020**

- A revision to the minimum staffing requirements for all hardware-secure residential child caring agencies was included in proposed changes to Chapter

0250-4-5-.07 "Standards for Residential Child Caring Agencies" in **October 2020.** The amendment provides there must be at least one direct care staff present for every eight youth during waking hours and at least one direct care staff present for every sixteen youth during sleeping hours. **Promulgation of the proposed revisions is currently in process.**

- Once revised rules are in place, the licensing division will monitor ratios at all hardware-secure residential child caring agencies as a part of the internal ratio compliance sampling noted under Finding 5 above. Any deficiencies will be noted in the licensing evaluation summary.

OBSERVATION 5

Wilder Youth Development Center staff did not maintain complete staffing documentation and did not comply with PREA staffing standards

RECOMMENDATION

PREA standards found in Title 28, *Code of Federal Regulations*, Part 115, Section 313(11)(c), require secure juvenile facilities to maintain a 1:8 staff-to-child ratio during resident waking hours and a 1:16 staff-to-child ratio during resident sleeping hours. The department recognized the staffing deficiencies and in April 2020 took action to correct the deficiencies by implementing a 12-hour shift staffing pattern to comply with the PREA staffing ratio standards. The department stated that the change has resolved the staffing issues. In August 2020, the department began storing shift rosters electronically to ensure staffing documentation is properly maintained. We will evaluate the effectiveness of the department's staffing changes during future audits.

ACTION OWNERS

Darren Goods, Deputy Commissioner, Office of Juvenile Justice
Misty Neely, Executive Director, Office of Juvenile Justice
Martha Shirk, Executive Director of Human Resources and Internal Affairs

CORRECTIVE ACTION COMPLETED

- Wilder daily shift roster is now stored electronically on departmental share drive and Office of Juvenile Justice Regional Director is now responsible for regular checks that staffing rosters are being stored properly. **Rosters are being stored electronically and checked regularly starting in December**

2020.

- Recruiting new staff and retention of current staff at Wilder has been ongoing throughout 2020 and will continue throughout 2021. The department has held several hiring events at the facility and has advertised open positions on social media. The department has also created a multidisciplinary Wilder Task Force to address and correct staffing and other issues at the facility. (See corrective action items for Observation 9)

OBSERVATION 6

Department management should address clarity and consistency in the use of restrictive behavior management techniques

RECOMMENDATIONS

The Commissioner and the department's Licensing Standards Committee should continue to review and revise the definition of seclusion in Rule 0250-04-08-.01(11) to clarify what incidents should be classified as seclusion. In addition, the Commissioner should consider revising the department's RBM rule to include language that clearly states the department's intent concerning RBM techniques and the circumstances in which law enforcement facilities can use these techniques. If necessary, the department should work with legislative members to amend statute to ensure clarity and intent.

The Commissioner should also ensure that management develops a rule to cover the use of RBM techniques at hardware-secure RCCAs and that the newly developed rule is consistent with the Wilder RBM policies.

ACTION OWNERS

Helen Rodgers, Assistant General Counsel
Mark Anderson, Director, Licensing

CORRECTIVE ACTION COMPLETED

- The department has worked since early 2020 on revisions to the rules establishing Minimum Standards for Juvenile Detention Centers and Temporary Holding Resources (Chapter 0250-04-08). The licensing standards committee finalized the proposed revisions on October 27, 2020. Promulgation of the proposed revisions is currently in process and will reflect provisions for the use of seclusion as

defined in SB 383/HB 1126, which became effective on May 25, 2021.

- The revision will clarify language originally included in the 2017 rules in the area of restrictive behavior management. This new wording will more clearly define the practice of seclusion while also providing distinguishing language for other restrictive management techniques that may not meet the criteria for seclusion but still require oversight and a regulated approach to practice. Once the revision to the rule is promulgated, the licensing division will apply the new requirements to its ongoing monitoring of restrictive behavior management at all Juvenile Detention Centers. (This addresses Concern 1)

- The proposed revisions will also remove language that provided an exception for law enforcement in the use of prohibited restraint techniques. This will re-establish the original intent of the rules to prohibit the use of tasers or any related "less than lethal" behavior management techniques by any staff in juvenile detention facilities. (This addresses Concern 4)

- Amend the rules for Residential Child Care Agencies (RCCA) (Chapter 0250-04-05), specifically establishing provisions for the state's two contracted hardware secure juvenile justice facilities licensed as RCCAs – Mountain View Youth Academy and Hollis Academy. Once the revision to the rule is promulgated, the licensing division will apply the new requirements to its ongoing monitoring of restrictive behavior management at all hardware secure residential child caring agencies. (This addresses Concern 2)

- These revisions will:

    - Include requirements pertaining to the use of restrictive behavior management at the contracted hardware secure facilities to more closely align with existing departmental policy (This addresses Concern 3); and

    - Establish new provisions for program staff to student ratios during sleeping hours to more closely align with existing departmental policy on ratios.

OBSERVATION 7

On December 29, 2019, the Commissioner appointed an interim Deputy Commissioner of Juvenile Justice who did not meet employment qualifications set forth in statute

RECOMMENDATION

Without meeting the statutory qualifications when filling positions, management may make decisions that negatively impact the children they serve. Specifically, the Commissioner's appointment of an interim Deputy Commissioner of Juvenile Justice without evidence of education, training, and experience in juvenile justice could place those children who require juvenile justice services at a higher risk.

ACTION OWNER

Commissioner Jennifer Nichols

CORRECTIVE ACTION COMPLETED

- While management takes issue with this observation, the interim deputy commissioner, who was hired in an interim position for 12 months and was the focus of this observation, retired in December 2020, as was the expectation when he took the position.

- The new Deputy Commissioner of Juvenile Justice, Darren Goods, started February 1, 2021. His qualifications meet the employment qualifications as he has a wealth of juvenile justice experience and is a graduate of LeMoyne-Owen College. In addition to creating and participating in prevention and mentorship programs for at-risk youth throughout his career, Deputy Commissioner Goods completed many hours of in-service training in the Memphis Police Department focused on juvenile justice and working with youth. He also completed courses in juvenile justice while earning his bachelor's degree in criminal justice. Deputy Commissioner Goods has years of involvement and interaction with the Shelby County Juvenile Court. He has spent many hours working with court and detention center staff regarding cases before the court. His experience and advocacy for youth include testifying during juvenile transfer hearings on behalf of youth charged with crimes whom he believed would be better served and treated in a juvenile justice facility rather than the adult judicial system. He has also served as a member of the board of directors of AGAPE Child and Family Services in Memphis.

OBSERVATION 8

The department's Office of Human Resources did not require staff to document and maintain verification of candidates' education and references required for hiring decisions

RECOMMENDATION

Without verifying employees' references and educational qualifications, the department cannot ensure employees meet the qualifications for their positions. As a result, the department may inadvertently place children at risk by hiring potentially unqualified employees. The Executive Director of the Office of Human Resources should ensure that staff verify and document that all employees meet job qualifications as required by Tennessee Department of Human Resources policies and state statute. In addition, the Commissioner of the Department of Children's Services should implement the necessary internal controls to ensure staff perform and document their verification reviews of employees' references and educational requirements.

ACTION OWNER

Martha Shirk, Executive Director of Human Resources and Internal Affairs

CORRECTIVE ACTION COMPLETED

- Created an internal control by establishing a new procedure to require Central Office manager or designee to review pre-employment documentation before approving new hires to be entered into Edison through ePAF. (Pre-employment checks include all background checks, references, and proof of education.) If background checks are not completed, files are returned to field HR staff and the candidates are not entered into Edison through ePAF. **Internal control created and new procedure established in December 2020.**

OBSERVATION 9

Department management should evaluate turnover rates

RECOMMENDATION

Based on our turnover analysis, we identified that the Wilder Youth Development Center's average turnover rate exceeded 20% for fiscal years 2018 through 2020 and was higher than the average turnover rate of 34.5% for adult correctional systems in Tennessee. Based on our discussions, management does not believe the turnover rate is a problem. Given the problems we identified in Finding 6, Finding 7, and Observation 5, management should consider evaluating the turnover for the Wilder Youth Development Center and determine the impact turnover has had on the Wilder employees and operations.

ACTION OWNERS

Martha Shirk, Executive Director of Human Resources and Internal Affairs

CORRECTIVE ACTION COMPLETED

- Recruiting and retention work at Wilder has been ongoing throughout 2020 and will continue throughout 2021.
    - Aggressive recruitment plan developed for Wilder by HR Recruiting Specialist with input from Wilder leadership, including **on-site job fairs or hiring events held in November 2020, March 2021, April 2021, and May 2021.**
    - Created a communications and marketing campaign focused on recruiting new staff, including videos, paid social media posts, outdoor advertising, and printed materials. **This is an ongoing action item.**
    - The Executive Director of HR has a specific job performance plan goal focused turnover and retention for the department, including Wilder; action steps include focus groups, meetings with leadership at Wilder and developing a recruiting and retention plan specific to the facility.
    - Created an HR Manager position at Wilder to work with facility leadership around turnover and retention; **as of May 26, the position is posted and the department is in the process of finding the best candidate.**